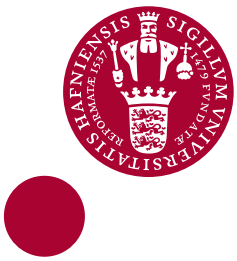

Social functioning in patients with first-episode psychosis

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agentic, personified and characterful?[11] If we think that the voices or their power relations have changed, does this actually persist beyond therapy, and why are gains apparently not maintained when compared with control interventions? It might be that we need to look beyond the individual and their voices to understand how social relationships and contexts, more broadly, might invoke relapse and distress once someone finishes therapy. Longitudinal qualitative research, possibly combined with ecological momentary assessment, could elucidate the potentially diverse and multifaceted factors contributing to changes relevant to the voice-hearer. We should applaud the efforts of the AVATAR team and the considerable benefits they have enabled for voice-hearers in their trial, but put simply, the question now is this—how does the conversation continue?

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Dissemination of early intervention facilities in many developed countries has led to an improved outcome for patients with first-episode psychosis.[1–3] However, this improvement does not necessarily mean that the illness trajectory is radically shifted or that the overall outcome of the illness can be described as positive. Studies have shown that, although most patients have remission of their psychotic symptoms, a higher proportion have continuous negative symptoms that are severely debilitating for their long-term functional outcome.[4] Even if early intervention services partly decrease these symptoms, there is a crucial need for new targeted treatment approaches.[5,6]

Social recovery therapy is a tool that can help increase the time spent in structured activity for people with a very low level of activity. To intervene in other people's lives can be a very difficult task, which requires understanding and respect for the values and culture of the person involved. The focus on everyday life in social recovery therapy has some promising elements, and seemingly can serve as a supplement to other established forms of individual support. It is only more recently that psychiatry has expanded its remit to offering professional involvement and support in everyday living once an inpatient stay has concluded, and social recovery therapy can be seen as an

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additional tool in helping people with certain types of mental illness return to living and playing a part in the community.

In *The Lancet Psychiatry*, David Fowler and colleagues present results of the SUPEREDEN3 randomised controlled trial[7] investigating the effects of adding social recovery therapy to early intervention services for enhancement of social recovery in patients with first-episode psychosis with severe social disability. The study addresses one of the most central problems facing early intervention services: how to help the functionally most disabled patients? The findings are promising—at 9 months, patients receiving social recovery therapy plus early intervention services (n=93) had an increase in the primary outcome of structured activity of 8·1 h (95% CI 2·5–13·6; p=0·0050) compared with those receiving early intervention services alone (n=90).

Fowler and colleagues have succeeded in recruiting a large group of the most vulnerable and disabled patients with first-episode psychosis, and the trial included two follow-up points and little attrition. The researchers should be commended for their focus on this group of patients and for their endeavour in recruitment and minimising dropout. The quality of the study is high, and the primary results clinically relevant and significant; however, we have three issues for consideration before general implementation is recommended.

First, although recruitment of 150 patients with severe social disability is impressive, alongside the high follow-up rate of 93% after 9 months, the number is still relatively low. The study protocol defines the study as a phase 2 proof-of-principle trial, and states that it will be followed up by a larger multicentre trial. We agree that this reproduction is necessary before recommendation of implementation.

Our second reservation concerns the secondary outcomes and analyses. The positive intervention effect found at 9 months in the primary analysis is lost at 15 months, mainly due to late improvement in the control group. If this is a true finding, one has to question whether the effect of the intervention is primarily to speed up an already ongoing recovery process. This function could in itself be beneficial, but whether it is of clinical importance should be considered. In the secondary analyses, the investigators used joint modelling to address the unequal drop out rate between the intervention and control groups. This analysis showed a sustained positive effect of the intervention after 15 months. Joint modelling is an appropriate model to control for missing data when the data are missing not at random, as in this study, but it assumes that non-attendance at follow-up is a sign of a worse outcome. This assumption might be correct, but participants could also dropout for other reasons (eg, remission and involvement in other activities).

Third, there might be a problem of circularity between the intervention and the outcome. An intervention targeted at increasing the weekly level of structured activity might engage the participants receiving the intervention better with services, therefore make them more likely to report back on their activity. A future reproduction of the study should carefully consider whether this potential source of bias should be addressed.

Despite these reservations, Fowler and colleagues' study provides one of the most promising developments for this severely debilitated patient population.

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